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Sen. Robert Meeks
Sen. Ryan Mishler
Sen. Sue Errington
Sen. Vi Simpson
Sen. Connie Sipes
Rep. Charlie Brown
Rep. William Crawford
Rep. Peggy Welch
Rep. Timothy Brown
Rep. Suzanne Crouch
Rep. Don Lehe

SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

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MEETING MINUTES[1]

Meeting Date:	**September 10, 2007**
Meeting Time:	**10:00 A.M.**
Meeting Place:	**State House, 200 W. Washington St., Room 404**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**3**

Members Present: **Sen. Robert Meeks; Sen. Ryan Mishler; Sen. Sue Errington; Sen. Connie Sipes; Rep. Charlie Brown; Rep. William Crawford; Rep. Timothy Brown; Rep. Suzanne Crouch.**

Members Absent: **Sen. Patricia Miller, Chairperson; Sen. Vi Simpson; Rep. Peggy Welch; Rep. Don Lehe.**

Rep. Tim Brown, chairing the meeting for Sen. Patricia Miller, called the meeting to order at approximately 10:15 am.

EDS and Managed Care Organization Providers Claims Payment and System Access Reports

Dr. Jeff Wells, Director of the Office of Medicaid Policy and Planning (OMPP), updated the Commission regarding access to managed care organization (MCO) providers. Dr. Wells distributed a document regarding availability by county in the Medicaid risk-based managed care program for: (1) general practitioners, family practitioners, and general internists; (2) OB/GYNs; and (3) pediatricians (see Exhibit #1).

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.in.gov/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

Dr. Wells distributed three maps showing the location of health providers by region for MDwise, one of the state Medicaid MCOs (see Exhibit #2). The three maps represented behavioral health providers, primary medical providers (PMPs), and specialists.

Dr. Wells also distributed a document showing the number of dentists and physicians by county participating the Indiana Health Care Program (see Exhibit #3). The data included the number of enrolled dentists, medical PMPs, and non-PMP physicians, as well as those actively billing the program, the percentage actively billing, and the members-to-provider ratios. In responding to a question as to what a reasonable members-to-provider ratio would be, Dr. Wells indicated that a standard hasn't been determined yet. Rep. Tim Brown suggested that a statewide average of this data and the amount above or below for each county would also be useful.

Mr. Mitch Roob, Secretary of the Family and Social Services Administration (FSSA), stated that coverage is not as good in smaller, more rural counties as it is in larger, more urban counties.

Responding to a question about what assurances exist that any increases in MCO physician reimbursement will actually reach physicians, Dr. Wells stated that OMPP will add in their MCO contracts a requirement that reimbursement increases be passed down to physicians. He added that FSSA would conduct compliance audits as well.

Responding to a question about the determination and notification plans for physician reimbursement levels, Dr. Wells noted that he was surprised at the complexity of this process and that the reimbursement change can affect federal cost effectiveness requirements, the Medicaid waivers, and the Medicaid forecast budget.

Responding to a concern about recruitment of physicians to participate in the Medicaid program, Dr. Wells stated that we need to increase participation, but fewer medical school graduates are looking at the primary care area as a career. Secretary Roob added that after sending notices and letters to non-participating physicians is a good idea, and will be done when the Healthy Indiana Plan is implemented.

Rep. Charlie Brown raised the question of how to encourage more physicians to enroll or to accept more patients in order to prevent Medicaid clients from having to travel long distances to access participating providers. Rep. Brown also stated that feedback is needed on what non-participating physicians need or want to participate. Mr. Zach Cattell, Indiana State Medical Association (ISMA), responded that the ISMA state convention would be occurring soon and discussions can take place at that time. Rep. Tim Brown indicated that it was his belief that reimbursement needs to be 90% of what commercial payers reimburse and that payment needs to occur within 30 days.

CHIP Reauthorization Update

Mr. Roob, Secretary of FSSA, updated the Commission on the progress of federal reauthorization of the Children's Health Insurance Program (CHIP or SCHIP). Sec. Roob distributed a document summarizing Indiana's current CHIP program and the proposed federal reauthorization (see Exhibit #4).

Sec. Roob stated that HEA 1678-2007 increased eligibility under CHIP to 300% of the federal poverty level, which would result in a potential increase in federal expenditures in Indiana of $50 million. However, if the proposed U.S. Senate bill that increases federal cigarette taxes by $0.61 passes, Indiana citizens would pay an additional $300 million in cigarette taxes with only $50 million of this money returning to the state. Sec. Roob stated that Indiana should not be a

donor state in health care. He added that both Indiana senators and two of the state's representatives voted for the bill. Sec. Roob distributed a document showing the 16 states that would benefit from the Senate proposal and the 29 states that would lose under the federal proposed bill (see Exhibit #5).

Sec. Roob informed the Commission that reauthorization is being considered in both a House bill and a Senate bill. He added that because the program expires September 30, 2007, the program will likely have at least a temporary reauthorization with discussions continuing for several months.

Sec. Roob stated that some states would choose to cover children with incomes between 300% and 400% of the federal poverty level, but he doesn't believe health coverage for this population in Indiana is a problem. The Bush administration has made a recent change by proposing that a state must enroll at least 95% of CHIP-eligible children to be allowed to provide coverage over 200% of the federal poverty level.

In response to a question as to what percentage of eligible Indiana children actually are enrolled in the program, Sec. Roob stated that approximately 70% of CHIP-eligible children and about 60% of Medicaid-eligible children are enrolled.

Members briefly discussed sending a letter to the Legislative Council to urge the Indiana congressional delegation to vote against the existing Senate bill. No further action was taken at this time.

Nursing Facility Closure and Conversion; Definitions and Funding Percentages

Mr. Steve Smith, Director of the Division of Aging, provided a slide show describing the nursing facility closure and conversion issue (see Exhibit #6).

The presentation included a brief history of the nursing facility closure and conversion issue beginning with the passage of SEA 493-2003 and the establishment of the nursing home Quality Assessment (QA) Fee in 2005. The presentation includes a detailed listing of the objectives and outcomes of SEA 493; a summary of Division of Aging expenditures for FY 2006 and FY 2007; a description of the objective of shifting the relative expenditures between institution-based health care delivery, support services, community services, and individual services; a comparison of the number of individuals receiving non-Medicaid services; a comparison of state strategies for controlling the supply of state-funded nursing facility beds, including certificate-of-need programs and moratoriums; and the outcomes and results of SEA 493,thus far, including outcomes such as declines in nursing home utilization, reductions in the Aged and Disabled Waiver wait list and the CHOICE wait list, etc.

Mr. Smith distributed a list comparing state-by-state expenditures for institutional services and community-based services (see Exhibit #7).

Mr. Smith also distributed a document describing the implementation status of SEA 493 (see Exhibit #8).

Mr. Smith added that the QA Fee was intended to be split between the state General Fund, with the remainder designated to enhance Medicaid reimbursement for nursing facilities. Since the expiration of the rule implementing the fund and because of the new reimbursement rule for nursing facilities, funds are no longer available for closure and conversion purposes.

Mr. Smith stated that there are approximately 522 nursing facilities in Indiana, of which 475 are

Medicaid-certified. The 475 facilities have an average occupancy rate of about 85%, and there is a wide variation in quality of the facilities. Mr. Smith added that the state would like to have some flexibility in closing facilities.

In response to a question as to whether statutory definitions of closure and conversion would help, Mr. Mitch Roob offered the following definitions:

> *Closure* - When a Medicaid-participating nursing facility completely ceases operation as a nursing facility.
>
> *Conversion* - When a Medicaid-participating nursing facility changes from providing institutional care to providing alternative, non-institutional care.

The Commission took no action on the definitions.

Mr. Mark Scherer, Indiana Health Care Association, provided the Commission additional information on the QA Fee. Mr. Scherer stated that when the QA Fee was enacted in 2003, $10 of the fee was to go into nursing facility reimbursement rates predicated on quality improvement. Suggestions or possibilities for distributing the remaining $10 amount included the following:

- Converting report card scores to a dollar value (e.g., $1.50 to $3.00)
- Providing an add-on payment for Alzheimer's units
- Incentivizing providers to help them get out of business
- Creating behavioral centers for violent residents
- Providing for sprinklers and smoke detectors
- Conducting user-satisfaction surveys

Responding to a question as to why control the supply of nursing home beds, Mr. Roob stated that most states regulate supply through a certificate-of-need program or moratorium and that if the beds are available, nursing facilities will market directly to hospitals to get hospital discharges.

Long-Term Care Continuum-of-Care Issues

Mr. John Cardwell, chairperson of the Indiana Home Care Task Force, described the preliminary results of three surveys conducted by the Home Care Task Force regarding issues affecting publicly funded home- and community-based services (HCBS) in Indiana. The surveys cover three topics: (1) patterns of service usage in the CHOICE and Medicaid waiver programs, (2) general priorities in Indiana's HCBS system, and (3) the initial impact of welfare privatization on low-income seniors who use Medicaid-funded home- and community-based services.

Mr. Cardwell's testimony included the following survey results:

- The state needs to continue full funding of the CHOICE program.
- The state needs to spend CHOICE dollars on CHOICE services, despite the impact of SEA 493 and the 300% of SSI income-eligibility standard for Medicaid waivers.
- The Area Agencies on Aging (AAA) need to be given more local decision-making authority and administrative power, which would streamline the system and make it more responsive to persons requiring home- and community-based services.
- Surveyors found no one who believes that SEA 493 has been fully implemented, although there have been positive gains made.
- Welfare privatization represents a tangible threat to senior citizens and persons with

disabilities who are disproportionately poor.
- The state currently has approximately 26,000 people in nursing homes, and this number would be under 13,000 if SEA 493 were properly implemented, CHOICE was fully utilized, and consumers were fully engaged and educated regarding long-term care.

Mr. Cardwell's written testimony is available as Exhibit #9.

Mr. Cardwell distributed a report entitled "What Citizens are Saying: A Report on the *Hearth and Health Summit* Regarding Home and Community Based Care in Indiana" published by The Generations Project, March 2007 (see Exhibit #10).

Mr. Cardwell also distributed a report entitled "Moving Forward: Senate Enrolled Act 493 and Long Term Care Rebalancing in Indiana" published by The Generations Project, January 2005 (see Exhibit #11).

Ms. Melissa Durr, Executive Director of the Indiana Association of Area Agencies on Aging, responding to a question concerning pre-admission screening interviews in hospitals, stated counselors not employed by a AAA are counseling patients in hospitals before the AAAs are notified and able to meet with the patient.

Ms. Linda Muckway, a CHOICE program client, described her experience on the CHOICE program and stated that being on CHOICE instead of Medicaid actually saves the state money because if she were on Medicaid, all of her medical costs would also be paid. She added that having to wait for services, often times for a minimum of six months, is counterproductive because in that amount of time, an individual's assets may be reduced to the point where the individual can no longer afford to live in the community rather than be on Medicaid. She further stated that the concept of money following the person does not work in the long term.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Statewide Contracting Issues

Ms. Judy Bunn, Executive Director of the Association of Indiana Home Medical Equipment and Service (AIHMES) providers, a trade association with 86 member home medical equipment companies, expressed the concern that the association members were not informed of the impending changes in the recent request for proposal (RFP) project for incontinence, urological, and ostomy supplies until the last minute. According to Ms. Bunn, when AIHMES was made aware of a project focused on contracting with a single provider for these services, AIHMES immediately requested a meeting to discuss this proposal as well as other options. AIHMES was informed at a meeting with OMPP that a sole-source-provider project/contract was basically a "done deal" even though no RFP was issued, and no Indiana provider would be able to bid. The project was stopped, and a formal RFP was posted. However, AIHMES believes that the language in the RFP was to a significant extent written to eliminate all but a few select providers from successfully complying with the bid requirements. AIHMES also believes that a mail order program will actually lead to a reduction in quality of service.

Ms. Bunn made the following suggestions:
- The state should negotiate manufacturer rebates, similar to existing pharmaceutical and hearing aid programs.
- The length of the contract in the RFP, stated as four years with two one-year renewals, seems to be excessive for an untried project; a two-year contract seems more appropriate, with an effective followup and study to be implemented at the end of the two years, before any additional contracts are awarded.

According to Ms. Bunn, AIHMES believes that recipients should have the freedom to choose their providers; wants all reputable providers to have realistic opportunities to provide Medicaid services; and as a responsible trade association, wants to work with the state on behalf of members and their patients to establish cost-effective, feasible provision of services to recipients and the state, while preserving the patient's freedom of choice.

Ms. Bunn's written testimony is available as Exhibit #12.

FSSA staff distributed a handout showing an overview and history of the RFP process for incontinence and ostomy products (see Exhibit #13). The document was not discussed.

The meeting was adjourned at about 12:45 pm.

The next meeting of the Commission is scheduled for October 4, 2007, at 10:00 am in the Senate Chambers of the State House.